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ABSTRACT

To examine alternatives to nursing home care, states have been testing home and community-based services under the Medicaid program. Information on the operations of the state projects will be vital to designing cost-effective alternative services in the future. The General Accounting Office (GAO) reviewed state reports to see if accurate, complete, and useful information was being collected. The results revealed that data from most states were inaccurate and not useful. Revisions by the Health Care Financing Administration (HCFA) of its reporting requirements and instructions were implemented in 1986 and should improve the accuracy and usefulness of states' reports. The findings also showed that the HCFA does not know how effectively states' home and community-based services substitute for nursing home care and cannot evaluate whether these programs increase or decrease Medicaid costs. Many people who have participated in community care demonstration projects would not have entered a nursing home had the community-based care been unavailable. To assume that all alternative care recipients use these services to prevent or postpone admission to nursing homes is unrealistic and could lead to false conclusions about program cost-effectiveness. GAO recommends that the administrator of HCFA develop measures of home and community-based services programs' ability to prevent or postpone nursing home care and use these measures to evaluate waiver program cost-effectiveness. (NB)

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United States General Accounting Office

GAO

Report to the Administrator, Health Care Financing Administration, Department of Health and Human Services

April 1987

# MEDICAID

# Determining Cost-Effectiveness of Home and Community-Based Services

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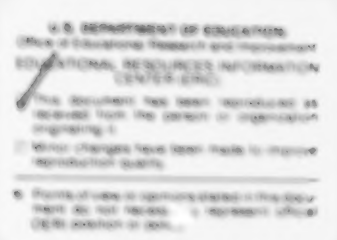

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GAO

**United States**
**General Accounting Office**
**Washington, D.C. 20548**

**Human Resources Division**

B-208492

April 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services

Dear Dr. Roper:

This report discusses efforts by the Health Care Financing Administration (HCFA) to evaluate the cost-effectiveness of the Medicaid home and community-based services program using cost reports submitted by states.

While HCFA's revised reporting requirements should improve the accuracy of states' program information, we recommend that HCFA develop information on the extent to which the program prevents or postpones the need for nursing home care. Without such information, the program's cost-effectiveness cannot be adequately evaluated.

Copies of this report are being sent to the Secretary of Health and Human Services and the Department's Office of the Inspector General. We will also send copies to congressional committees having oversight responsibility for the Medicaid program and to other interested parties upon request. We would appreciate being advised of any actions you plan to take on our recommendation.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

# Executive Summary

## Purpose

Are there viable alternatives to nursing home care? States are addressing this question by testing the use of home and community-based services under the federally financed Medicaid program. The answers will be important for long term care management, particularly as the elderly population burgeons over the next 20-30 years.

Information on the operations of the state projects will be vital to designing cost-effective alternative services. GAO reviewed reports from the states on the Medicaid home and community-based services program to see if accurate, complete, and useful information was being collected.

## Background

In passing the 1981 Omnibus Budget Reconciliation Act, the Congress authorized adding home and community-based services to the Medicaid program through the use of waivers. The intent was to offer alternatives to nursing home care without increasing Medicaid costs. In principle, by providing certain kinds of social services (such as help with cooking, housekeeping, or such personal care needs as bathing) to people living in the community, nursing home care can be avoided or postponed.

To provide these alternative services, traditional Medicaid requirements must be waived by the Secretary of Health and Human Services. The state must assure the Department of Health and Human Services (HHS) that its estimated Medicaid costs with the added home and community-based services will not exceed its estimated Medicaid costs had no waiver been approved. To evaluate the costs experienced by these alternative care programs, the Health Care Financing Administration (HCFA), the HHS component that administers Medicaid, requires states granted waivers to report cost and recipient data.

## Results in Brief

HCFA has not obtained the information it needs to evaluate the Medicaid home and community-based services program. Information collected during the first 5 years of the program has been neither accurate nor consistently reported and consequently is not useful for evaluating the operating experience of most waiver programs. To remedy these shortcomings, HCFA recently revised its reporting requirements and instructions. GAO believes the changes will improve the accuracy and usefulness of states' reports.

But to effectively evaluate the program, HHS must find ways to discriminate between those who use waiver services instead of nursing homes

and those who use waiver services to augment their care in the community. HCFA now assumes that all those receiving home and community-based care otherwise would use nursing homes. As a result, when the costs of care for waiver recipients are less than the costs of nursing home care, HCFA concludes that the waiver is cost-effective. HHS-funded research and demonstration projects do not support this assumption. Many people who have participated in community care demonstration projects would not have entered a nursing home had the community-based care been unavailable. As a result, community-based alternatives have frequently increased costs to Medicaid.

## Principal Findings

### Most States' Data Inaccurate and Not Useful

Regional officials with oversight responsibility for the home and community-based program assessed the majority of states' reports to be neither accurate nor useful for assessing cost-effectiveness. GAO's audit work in two states corroborated these conclusions. The reports of these states showed that the states varied in interpreting the requirements, were given inconsistent guidance by HCFA, and needed to add new data to their information systems to produce the reports. GAO's analysis of the systems used to develop the report data revealed that cost and recipient data were not accurately nor consistently reported.

Regional officials attributed the reporting problems to delays by HCFA in specifying the reporting requirements and to problems experienced by the states in understanding the instructions, reprogramming their information systems to collect the required information, finding that the systems were inadequate to generate the needed data, and establishing operating and billing procedures for this new program.

### Reporting Requirements Improved by HCFA

In September 1986, HCFA revised the reporting requirements and instructions for the home and community-based services program. The new requirements take effect for reports due December 1986 and later. Both regional and state officials believe that the changes represent an improvement and expect the new data submitted by states will be more accurate and useful than the old. Also, HCFA has expanded its review of

the reports to include an evaluation of the system a state uses to generate its report. These changes should improve the quality of information available to HHS and the states for comparing unit costs of recipients who use nursing homes and those who use alternatives.

## Measures of Cost-Effectiveness Still Inadequate

But to measure the cost-effectiveness of waiver programs, HCFA needs to know more than comparative costs. The HHS-funded research and demonstration projects that generally preceded the home and community-based services program also tested the feasibility of long term care alternatives. These projects demonstrated that, unless the alternative services are provided in lieu of nursing home care, total Medicaid costs can increase. For example, the channeling demonstration project completed in 1986 increased costs by 14-28 percent because the alternative long term care services offered did not replace nursing home or hospital care. Recipients of community-enhanced services used nursing homes and hospitals to the same extent as those who did not receive such services.

HCFA does not know how effectively states' home and community-based services substitute for nursing home care and cannot evaluate whether these programs increase or decrease Medicaid costs. HHS research results indicate that to assume that all alternative care recipients use these services to prevent or postpone nursing home admissions is unrealistic and could lead to false conclusions about program cost-effectiveness.

GAO believes that HCFA should provide a more realistic basis for evaluating whether home and community-based programs increase or decrease Medicaid costs. For example, instead of assuming that all programs are effective alternatives for nursing home care, HCFA could require that states develop actual information needed to measure the extent to which their waiver programs replace the need for nursing home care. Alternatively, HCFA could use the actual results of its research and demonstration projects as a measure of institutionalization prevented by the programs.

## Recommendations

GAO recommends that the Administrator of HCFA develop measures of home and community-based services programs' ability to prevent or postpone nursing home care and use these measures to evaluate waiver program cost-effectiveness.

## Agency Comments

GAO did not obtain agency comments on this report.

# Contents


| | | |
|---|---|---|
| Executive Summary | | 2 |
| Chapter 1 Introduction | | 8 |
| | Background | 8 |
| | Objectives, Scope, and Methodology | 10 |
| Chapter 2 Problems With HCBS Cost Reporting | | 12 |
| | HCBS Information Not Reliable or Useful | 12 |
| | Revised Reporting Requirements Should Improve Quality of Data | 16 |
| | Evaluating HCBS Cost-Effectiveness | 17 |
| | Conclusions | 20 |
| | Recommendation | 20 |


**Abbreviations**

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| GAO | General Accounting Office |
| HCBS | home and community-based services |
| HCFA | Health Care Financing Administration |
| HHS | Department of Health and Human Services |

# Introduction

Providing long term care services to the chronically ill in their homes and communities offers an alternative to costly nursing home care. Such an alternative may be less expensive than 24-hour residential care and may be preferred by individuals wanting to maintain community ties. Also, viable alternatives to nursing homes could help meet the increased demand for long term care services expected in the next 20 to 30 years as the elderly population increases dramatically.

Medicaid has become the logical testing ground for long term care alternatives. As the federal grant program that supports state medical assistance programs to the needy, it funds a large part of the nation's nursing home care. In 1985, Medicaid paid about $16 billion of the $37 billion nursing home bill. Even middle-class elderly depend on Medicaid nursing home care when their own insurance and resources are inadequate to cover this expense.

## Background

In 1981, the Congress introduced home and community-based services (HCBS) into Medicaid through the Omnibus Budget Reconciliation Act of 1981. The act authorized the Secretary of Health and Human Services to waive traditional Medicaid requirements and allow states to provide HCBS. To receive a waiver, a state must show, among other things, that its estimated Medicaid costs with the HCBS program would not exceed estimated Medicaid costs without HCBS. By establishing the requirement that HCBS programs not increase Medicaid costs, the Congress recognized that alternatives to nursing home care such as HCBS are not inherently cost-effective. While HCBS unit costs generally are lower than nursing home costs, the program can cost more than nursing home care if more units of care are delivered or if HCBS represents supplemental services rather than substitutes for nursing home care. The Congress, therefore, authorized HCBS as a substitute for nursing home care, not as a supplemental home care benefit for those who would remain in the community even if HCBS were unavailable. It gave the Secretary authority to end waivers that did not prove cost-effective.

Under HCBS, states can offer such social services as case management to locate, coordinate, and monitor patient services; homemaker services to assist in such general household activities as meal preparation; and respite care to provide room and board and other services on a short-term basis when a patient's normal caretaker is absent or needs relief. In theory, providing such nonmedical assistance can enable individuals to live in the community, thus avoiding or delaying nursing home care. HCBS programs have been under way for 5 years. As of March 31, 1986,

the Department of Health and Human Services (HHS) had approved 130 waiver requests from 46 states to offer various types of HCBS programs. Some states have tried relatively small programs, others have implemented statewide efforts. Overall, HCBS programs represent a minor portion of the Medicaid budget; total fiscal year 1985 expenditures for HCBS were $295 million.

To be granted a 3-year waiver to operate an HCBS program, one of many requirements a state must meet is to assure the Secretary of HHS that its expected Medicaid costs with the added HCBS program will not exceed its expected Medicaid costs if no waiver were granted. To do so, states use a formula developed by the Health Care Financing Administration (HCFA), the HHS agency that administers Medicaid, for estimating Medicaid costs. The formula compares the state's average per capita costs for long term care recipients with and without the waiver to estimate how HCBS will affect the state's Medicaid costs.

Once granted a waiver to operate an HCBS program, the state must file annual reports with HCFA on the waiver's effects on (1) the type and costs of medical assistance provided by the state and (2) the health and welfare of the HCBS recipients. Before September 1986, the primary reports used by the states were:

- HCFA Form 372, "Annual Expenditure Report for Home and Community-Based Services," providing data on the numbers of HCBS and nursing home recipients, these recipients' total Medicaid costs (including both long term care and acute care service costs), and annual information on the impact of the HCBS program on the health and welfare of the recipients; and
- HCFA Form 371, "Annual Report for Home and Community-Based Services Waivers," providing information on the long term care costs of recipients under the waiver.

In September 1986, HCFA consolidated the two forms into a revised Form 372 and eliminated the Form 371 requirement. HCFA will use information from the revised HCBS report to describe the costs and recipients served by the program, assess the program's cost-effectiveness, and evaluate the appropriateness of renewing a waiver.

Since the inception of the HCBS program, three HCFA components in succession have been responsible for the Form 372. The Office of Research and Demonstrations held this responsibility until November 1984, when it was transferred to HCFA's Office of Management and Budget. In March

1985, the Bureau of Quality Control assumed responsibility for the form.

## Objectives, Scope, and Methodology

Our objectives were to evaluate the accuracy of data collected through the Form 372 and to determine whether HCFA had the information it needed to judge the cost-effectiveness of the states' HCBS programs. HCFA needs reliable information on these programs to help it decide whether to continue or discontinue them. Further, should HCBS become a standard Medicaid service, cost information collected from the waiver programs could reveal ways to design more effective programs.

We approached our objectives from several perspectives—obtaining detailed information by checking Form 372 reports and surveying the HCFA regions on their experience with the report and the states on their reactions to planned report changes. To obtain a detailed understanding of the reports and how states compiled the data, we worked on site in two states—Louisiana and Virginia—and reviewed their reports in detail. We judgmentally selected these states' programs for the following reasons:

- Louisiana's HCBS waiver for adult day care and habilitation, because it was one of the first three states awarded an HCBS waiver, served a large aged/disabled and mentally retarded population, and provided more than one waiver service to this population. Further, HCFA officials identified Louisiana as a state that had problems completing its HCBS cost reports and had noted some problems in the completion of a related Medicaid statistical report.
- Virginia's HCBS waiver for personal care services, because it provided only one waiver service to a small aged/disabled population and had received a favorable review from HCFA regarding its waiver and its preparation of a related statistical report.

In both states, we discussed the waiver program and the preparation of the Form 372 with state officials and reviewed the states' Form 372 data-gathering methodology. Also, we tested the logic of the two states' Form 372 data processing by independently producing a Form 372 report using a sample of Medicaid recipients. These steps were used to judge the accuracy of the states' reports.

To gain a broader perspective about problems we identified from our detailed work in Virginia and Louisiana and their causes, we sent a questionnaire to HCFA regional office officials who had direct contact

with states operating waiver programs. In our questionnaire, officials of each of the 10 HCFA regional offices were asked to address:

- the extent of their review and use of the HCFA Form 372,
- the adequacy of the HCFA Form 372 instructions,
- the adequacy of guidance provided by HCFA's Central Office, and
- the extent of improvement provided by the revised Form 372 and instructions.

Also, we asked HCFA regional officials to evaluate the accuracy of Form 372 reports for all states within their regions. This information helped us to corroborate reporting problems we had uncovered during our detailed audit work in Virginia and Louisiana.

To elicit states' opinions on the revised Form 372, we contacted state officials participating in the HCBS Waiver Technical Assistance Group. This group, created by the State Medicaid Director's Association, consisted of one state representative from each HCFA region. The 10 states were Colorado, Connecticut, Illinois, Kansas, Kentucky, New Jersey, New Mexico, North Carolina, Oregon, and Virginia. These representatives had been given the opportunity to comment on a draft of the revised Form 372 and to attend a meeting to discuss their comments. Using a structured telephone interview, we asked states to compare certain aspects of the original and revised Forms 372 and to discuss problems they had had or anticipated having in completing them.

To evaluate whether HCFA would be able to use states' reports to judge program cost-effectiveness, we compared the data that would be available from the revised Form 372 with the information needed to determine cost-effectiveness. To identify needed information, we reviewed reports on HCFA-funded research and demonstration projects aimed at evaluating the cost-effectiveness of community-based alternatives to nursing home care. The question of whether elderly individuals used HCBS programs in place of nursing homes proved a critical factor in the cost-effectiveness equation.

Our review, done primarily between June 1984 and April 1986, was performed in accordance with generally accepted government auditing standards.

# Problems With HCBS Cost Reporting

HCFA lacks good information with which to compare the costs of HCBS and nursing home care and to measure the extent to which states' HCBS programs prevent or postpone an individual's use of nursing home care. Without this information, HCFA cannot determine whether HCBS programs provide alternative care without increasing Medicaid costs.

Although HCFA has collected extensive data to compare costs for HCBS and nursing home recipients, the original reporting requirements were not well designed or executed. As a result, information collected during the first 5 years of the program is generally not accurate or consistent and consequently not useful for evaluating the waiver programs. HCFA revised its reporting requirements in September 1986 and expanded its reviews of reports to include an assessment of how the information was developed by states. With these changes, HCFA should know how the Medicaid costs of HCBS recipients compare with the costs of nursing home residents.

To evaluate whether states' HCBS programs are cost-effective, HCFA also needs to know how many recipients would have entered a nursing home had HCBS programs been unavailable. Unfortunately, HCFA has no specific information on this, but assumes that 100 percent of HCBS clients use HCBS services instead of nursing home care.

Judging from HCFA research results, however, we believe this assumption is unrealistic and will bias HCFA to conclude that states' HCBS programs are generally cost-effective. Among recipients of HCBS-like services in HCFA-funded research and demonstration projects, between 10 and 60 percent used the services to delay or avert nursing home care. The discrepancy between these actual results and HCFA's assumptions about program success lead us to conclude that, to evaluate whether HCBS alternatives are cost-effective, HCFA needs better measures of how well the waiver programs substitute for nursing home care.

## HCBS Information Not Reliable or Useful

Information collected by HCFA on the Form 372 has not been accurate or useful for making HCBS program decisions. States had difficulties interpreting the requirements and redesigning their systems to comply with them. The reporting instructions were incomplete and unclear, and guidance from HCFA was inconsistent.

## Problems Caused by Design of Report

In several ways, the Form 372 differed from other Medicaid statistical reports. Other Medicaid reports typically collect on a fiscal year basis statistical data concerning recipients and payments for medical services. But the Form 372 required states to collect data to coincide with the dates of the waiver period (which typically differed from the state or federal fiscal year) and include the costs of services delivered during that 12-month period (irrespective of when they were paid for).

The form also required that states report all the associated costs for three types of recipients—nursing home residents, "deinstitutionalized" recipients who had left the nursing home to receive HCBS, and "diverted" recipients who had not been in a nursing home immediately before their entry into the HCBS program. This kind of cost analysis had not been required by other Medicaid reports that compiled data based on Medicaid eligibility categories. Because of these differences, states had to change their automated systems to produce the reports on Form 372.

When we checked the systems in Louisiana and Virginia, we found that both states had made errors in producing the reports. Recipients were miscounted or characterized incorrectly and costs not accumulated correctly. For example, Virginia's system under-reported costs for certain waiver recipients because it missed costs corresponding to certain periods of HCBS eligibility. Louisiana did not correctly discriminate between diverted and deinstitutionalized HCBS users and reported some HCBS recipients as nursing home patients.

## Differences in Interpretation Noted

Because the HCBS reporting requirements and instructions were not clear, states interpreted the requirements differently. For example, our case studies in Virginia and Louisiana showed that they interpreted the following differently:

- Reporting of Medicaid costs. The original Form 372 did not indicate whether states should report all Medicaid costs incurred during the year or only costs incurred while recipients were in the waiver program or in a nursing home. But HCFA officials told us that they expected reporting of total annual Medicaid costs for both HCBS and nursing home users (even if a person was using neither waiver services nor nursing home care at the time other Medicaid costs were incurred). This was how Louisiana reported costs, but Virginia interpreted HCFA instructions to require them to report cost of HCBS recipients only while a person was receiving HCBS, although reporting costs for nursing home recipients for the entire year.

- Definition of deinstitutionalized recipients. HCFA has not defined this term. Virginia considered a deinstitutionalized HCBS recipient as one who had been in a nursing home up to 5 days before entering the HCBS program. In its first two reports, Louisiana considered deinstitutionalized any HCBS recipient who had been in a nursing home before using HCBS, no matter how much time had elapsed. After we questioned this interpretation, Louisiana revised its definition of a deinstitutionalized HCBS recipient to be one who was in a nursing home within 24 hours of HCBS admission.

Difficulties interpreting the requirements were faced by many states, according to our questionnaire results. Overall, at least 26 states asked HCFA regional officials to clarify the HCBS reporting requirements. Specifically, three or more states questioned

- how to report recipients who change eligibility categories during the year,
- what time period should be considered as "immediately prior" to HCBS enrollment in defining the deinstitutionalized population,
- how to complete the section of the form related to the health and welfare of the recipients,
- whether to report costs incurred by recipients before entering or after leaving the waiver program or a nursing home,
- how to count days of coverage,
- where to report costs of recipients discharged from HCBS into a nursing home, and
- how to count recipients and report costs for waiver recipients whose share of Medicaid expenses exceeded their HCBS costs.

Changing responsibility for the report probably also contributed to states' receiving inconsistent interpretations of the reporting requirements. Between June 1983, when the first Form 372 was submitted, and March 1985, when report responsibility was transferred to HCFA's Bureau of Quality Control, three HCFA components in succession had responsibility for the Form 372. Only two HCFA regions considered HCFA Central Office guidance to be consistent among the three components.

## State Data Not Checked

HCFA did little to review or use the Form 372 data. Of the 55 Forms 372 submitted by states through March 1985, HCFA's Central Office reviewed 27. After the transfer of report responsibility in March 1985, the report review backlog was reduced, but HCFA rejected most reports because of inconsistencies or discrepancies. As of July 15, 1985, HCFA had accepted

10 of 78 reports states submitted. The lag between states' submission of the reports and HCFA Central Office review averaged 258 days for reports covering states' first year of HCBS operations and 113 days for reports covering the second year of operations. In most cases, reports covering years 1 and 2 were reviewed concurrently. Thus, states were unable to correct year 1 mistakes before they prepared the year 2 report.

According to our questionnaire results, 8 of the 10 HCFA regions undertook some review of the Form 372 but the reviews generally were limited. One region checked only for mathematical errors; another to be sure the form was signed and adequately described the waiver's impact on the health and welfare of recipients. Others checked the report for completeness, internal consistency, and data comparability with other reports. None of the regions routinely reviewed the methods used to obtain the Form 372 data, nor did any test the way specific recipients were reported.

Generally, the regions did not understand what review they should undertake and often did not feel capable of answering states' questions or reviewing submitted reports, according to the regions' responses to our questionnaire. Only 3 of 10 regions believed they had generally adequate guidance on their review responsibilities before November 1984, when HCFA's Office of Management and Budget assumed report responsibility; 5 of 10 felt that the review guidance had improved to at least adequate since that date. In terms of their ability to review the report and/or answer states' questions, only three regions felt at least moderately capable before November 1984 and seven regions after.

Regions that had reviewed the states' Forms 372 noted a number of reporting deficiencies. These included such problems as (1) significant differences between Form 372 data and data on other Medicaid reports and in the states' estimates included in the waiver request and (2) errors in recipient counts. According to the regional officials, factors contributing to the reporting deficiencies included

- states not understanding the Form 372 instructions,
- delays by HCFA specifying the reporting requirements and instructions,
- states' problems implementing major reprogramming of their information systems to comply with HCFA reporting requirements,
- difficulties in the start-up of the state waiver program, and
- inadequate data base(s).

In summary, the Form 372 problems resulted in HCBS data that generally were not reliable. According to our questionnaire results, officials representing 8 of the 10 HCFA regions said they lacked confidence in most states' Form 372 data accuracy and usefulness. When asked to comment on individual state reports, regional officials said they lacked confidence in the accuracy of the data for 52 percent of the states and in its usefulness in evaluating cost-effectiveness for 56 percent of the states.

## Revised Reporting Requirements Should Improve Quality of Data

In September 1986, HCFA revised and improved the Form 372 and its instructions and began receiving data under the revised requirement in December 1986. In revising the Form 372, HCFA

- reduced the states' reporting burden by combining the HCFA Forms 371 and 372;
- updated the report's data elements to reflect the requirements of final HCBS regulations, issued in March 1985;
- allowed a direct item-by-item comparison between state estimates and their actual experience; and
- made the instructions more specific.

The revised form should improve HCFA's ability to compare the costs of services provided to nursing home and HCBS recipients. Data are to be collected for only those time periods during the waiver year when recipients are either in a nursing home or in the waiver program. The original form collected data for costs incurred any time during the year, thus confounding the comparisons that could be made between the costs of HCBS and nursing home care. In addition, data reported are to be based on a recipient's level of care, i.e., whether the recipient was in or would have been in an intermediate care or skilled nursing facility or an intermediate care facility for the mentally retarded. This allows more specific comparisons between HCBS recipients and their nursing home counterparts than the original requirements.

The revised Form 372 also collects information on HCBS recipients who become eligible for Medicaid services based on more liberal income eligibility rules usually applied to only institutionalized individuals. This information helps HCFA and states gauge how many recipients qualified for HCBS under these liberalized eligibility rules. Had these individuals not entered the HCBS program, they would not have been eligible for other Medicaid services.

Generally, states we contacted that had an opportunity to review the revised Form 372 and HCFA regional offices that we surveyed found the data requested on the revised form an improvement. Further, both the states and regions believed the revised form would be useful. Of the 10 states contacted, 7 indicated they would use the revised form, primarily to monitor the cost-effectiveness of the waiver program and the utilization of services within the program.

Although the revised Form 372 is an improvement, it may be more difficult to complete. Half the HCFA regional officials we surveyed believed the revised form will be easier for states to complete, but states did not share this opinion. Of the 10 states we contacted, 8 indicated that the revised form would be more difficult to complete, specifically noting difficulties in reporting data by level of care and collecting data for only time periods when recipients are receiving HCBS or nursing home care.

Also, HCFA is expanding its review of data submitted on the Form 372. Guidelines have been drafted to add to the annual review of states' HCBS waivers an element to evaluate the validity of the data reported on the Form 372 and the ability of the states' systems to produce valid data. HCFA regional staff will be asked to interview state officials regarding the preparation of the Form 372, examine a state's written procedures for producing the form, and review data files and waiver claims samples to verify the presence of data elements necessary for HCBS reporting.

## Evaluating HCBS Cost-Effectiveness

In authorizing HCBS waivers, the Congress intended that aggregate Medicaid costs be no greater with the HCBS program than they would be were no waiver services available. To help ensure this, states must not only control the costs of services provided to HCBS recipients but also carefully target waiver services to individuals who would enter a nursing home if home and community-based services were not available. Services provided to individuals who would not have entered a nursing home represent additional costs to Medicaid and could offset any savings realized by providing HCBS at a lower per capita cost than nursing home services.

But the critical program question of whether HCBS programs increase or decrease Medicaid costs cannot be answered by the Form 372 data alone. With its revised reporting requirements, HCFA can compare nursing home and HCBS per capita costs. To evaluate HCBS programs' effects on total Medicaid costs, HCFA must also know the extent to which HCBS programs prevent or delay nursing home admissions.

HCFA does not, however, have the answer to this important question. Developing the necessary information for each state program could be difficult and expensive, in our opinion. It would require controlled studies to quantify differences between HCBS users and similar nonusers, which HCFA has not required of the states. Instead, HCFA evaluates waiver cost-effectiveness by assuming that all HCBS recipients would otherwise use nursing home care. We believe this assumption is unrealistic.

## Potential Nursing Home Clients Hard to Identify

States assure HCFA that HCBS recipients will be screened to establish that they need the level of care provided in a nursing home. But HFCA projects testing the concept of alternative long term care have shown that it is difficult to identify individuals who in fact would enter institutions were no alternative services available. In a 1982 report,[1] we reviewed the evaluations of 11 HCFA research and demonstration projects that offered expanded home health care services primarily to the elderly. To screen potential clients and identify those at risk of being institutionalized, the projects used a variety of client assessment instruments combining measures of dependence, disability, diagnosis, prognosis, and living arrangements.

But the criteria used did not accurately identify those who would eventually enter nursing homes, demonstration results indicated. For example, the Georgia Alternative Health Services Project found that only 16 and 22 percent of the control group were admitted to nursing homes during the project's first and second years, respectively. Thus, for the majority of experimental group clients receiving home and community-based services under the project, these services represented added costs for a new Medicaid benefit rather than a cost-effective substitute for nursing home care.

Similar low nursing home use by the control or comparison group was experienced by other demonstration projects. In one, only 6 percent of the comparison group used skilled nursing facilities during the second year of the project. In another, only 21 percent of the control group used skilled nursing facilities.

More effective in targeting alternative services to a high-risk population was the South Carolina Community Long Term Care project. Nursing

[1] The Elderly Should Benefit From Expanded Home Health Care but Increasing These Services Will Not Insure Cost Reductions (GAO/IPE-83-1), Washington, D.C., Dec. 7, 1982.

home use by its control group after 18 months indicated that about 60 percent of the population receiving alternative services would have been institutionalized had these services not been available. Apparently, the project improved its targeting by emphasizing preadmission screening and using hospitals as its major source of referrals.

## In Channeling Demonstration, Alternative Care More Costly

A test of whether providing carefully managed community-based long term care could help control overall long term care costs, the National Long Term Care Channeling Demonstration, was completed in 1986. Channeling was expected to achieve its effects principally by substituting community care for more expensive institutional care. The project was conducted from 1980 through 1984 at 10 sites. Two channeling models were tested:

- The basic model provided primarily case management using existing support service programs, and
- The financial control model expanded service coverage and provided additional funds to finance the services needed.

Participants were individuals at high risk of entering a long term care institution. They had to be at least 65 years old, have a specified level of functional disability, and have unmet needs for two or more services or have a fragile informal support system such as few or no informal caregivers.

The research plan used an experimental design to compare channeling's outcomes to what would have happened in its absence. Eligible individuals were randomly assigned to a treatment or control group, with the control group relying on whatever services were available in the community absent the channeling project. Follow-up for both groups occurred at 6 and 12 months, and for half the sample there was additional follow-up at 18 months. About 6,300 people participated in the project.

HCBS-type services did not keep frail elderly out of hospitals or nursing homes, the channeling experiment showed. At the 12-month follow-up, 13-14 percent of the control groups were in nursing homes compared with about 11 percent of those who received community services under the channeling projects. Nor was hospital use significantly reduced. Because nursing home and hospital use was not reduced by channeling, costs increased by 14-28 percent to pay for the alternative long term

care services. Like other demonstrations, the channeling project had difficulty identifying individuals at high risk of being institutionalized.

## Actual Measures of Success Needed

Instead of assuming that all HCBS users otherwise would have used nursing home care, HCFA needs to develop actual measures of the extent to which the waiver programs postpone or prevent institutionalization. To do so, HCFA could

- require that states develop specific information on how effectively their HCBS programs target services to those who would otherwise use nursing homes, or
- if state-specific information proves too expensive to collect, use the results of HCFA research and demonstration projects as the measure of institutionalization prevented by HCBS programs.

With better measures of HCBS's effects on institutionalization, HCFA can use states' data from the revised Form 372 to evaluate whether HCBS programs are accomplishing their legislative intent of providing less costly substitutes for nursing home care.

## Conclusions

Experimentation with long term care alternatives continues under the Medicaid HCBS waiver program, allowing HCFA to learn from the numerous state programs now under way. To make realistic evaluations and to improve designs of workable HCBS programs, HCFA needs reliable information on recipients and costs of services and good insights about each program's ability to curb nursing home use.

To date, HCFA has not had the information needed to evaluate HCBS programs. The agency has, however, recognized problems with its reporting requirements and made substantial revisions. But the revised reports will not allow HCFA to evaluate how effectively HCBS programs substitute for nursing home care. HCFA needs to develop information on the extent to which HCBS programs avert institutionalization of recipients—a critical factor in evaluating their cost-effectiveness.

## Recommendation

We recommend that the Administrator of HCFA develop measures of HCBS programs' ability to prevent or postpone nursing home care and use these measures to evaluate the cost-effectiveness of the waiver programs.

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